PAGE #2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44A114	A. BUILDING _____ B. WING _____	06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation and interview the facility failed to monitor the self-administration of medication for 1 resident (#57) of 25 residents reviewed. The findings included: Review of the facility policy Self-Administration revised August 2006, revealed "...Self-Administered medications must be stored in a safe and secure place, which is not accessible to other residents...Staff shall identify...medications found at the bedside that are not authorized for bedside storage..." Medical record review revealed Resident #57 was admitted to the facility on 4/30/12, with diagnoses including Scoliosis, Anxiety, Depression, and Hypertension. Medical record review of the annual Minimum Data Set (MDS) dated 3/21/15, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 (indicating the resident was cognitively intact for daily decision making). Medical record review of the Care Plan dated 4/3/15, revealed "...Problem onset 4/3/15...I use eye drops...wash your hands before administering	F 176	1. Resident #57's medications were removed from bedside on 06/08/15. On 06/09/15, the resident was reassessed for self administration of medications and found to be unsafe to self administer medications. The physician was notified and medication orders were clarified. The care plan was updated on 06/09/15. 2. By 06/18/15, Nursing Administration completed a 100% reassessment of all residents who self administer medications with no issues identified. 3. On 06/12/15, an order was added to all residents who self administer medications for the charge nurse to "Check all medications kept at bedside for safety and compliance" each shift. Nurses were alerted to this via the message board on the electronic health record system from 06/12/15 through 07/01/15. 4. The Director of Nurses, or designee, will review the Medication Administration Records each month during recapitulation to ensure compliance with this monitoring. Issues will go to the Quality Assurance Committee for resolution.	07/30/15

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy French | TITLE: Administrator | (X6) DATE: revised 07/27/15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 176	Continued From page 1 my drops..." Medical record review of the Physician's Recapitulation Orders dated 6/2015 revealed no order for self-administration of the Systane (lubricant) Eye Drops and no order for Refresh (lubricant) Eye Drops. Medical record review of a Physician's Telephone Order dated 6/4/15, revealed "...D/C (discontinue) Systane Eye Drops..." Observation on 6/8/15, at 3:05 PM, in the resident's room, revealed 2 bottles of Systane eye drops and 1 bottle of Refresh Eye Drops on the resident's bedside table. Interview with Resident #57 on 6/8/15, at 3:11 PM, in the resident's room, with Licensed Practical Nurse (LPN) #1 present, revealed the resident had administered the Systane eye drops twice on 6/7/15, and once on 6/8/15, and was unsure of the last time she had used the Refresh Eye Drops. Interview with LPN #1 on 6/8/15, at 3:15 PM, at the Station 3 Nurse's Station, confirmed the eye drops were not stored properly at the bedside. Continued interview revealed the Systane Eye Drops had been discontinued on 6/4/15, there had been no order for the Refresh Eye Drops, and the facility had failed to remove the Systane eye drops from the bedside when discontinued, and had failed to obtain an order for the Refresh eye drops. Interview with the Director of Nurses (DON), on 6/10/15, at 8:11 AM, in the DON's Office, confirmed the facility had failed to remove the	F 176		

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F 176	Continued From page 2 Systane eye drops from the bedside when discontinued, had failed to obtain an order for the Refresh eye drops, and the facility failed to follow the policy for Self-Administration of Drugs.	F 176	1. On 06/25/15, the activity director conducted an audit of preferences for residents who eat in the dining areas on the 3rd and 4th floors regarding eating at a dining table or eating on over bed tables for meals. Six of the interviewable residents expressed the preference of eating at a table and two expressed the preference to eat on over bed tables or at a table. Those residents who choose to eat on over bed tables for meals will be care planned accordingly.	07/30/15
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a homelike environment for dining in 2 of the 3 dining rooms observed. The findings included: Observation on 6/8/15, at 11:30 AM, in the 3rd floor dining room, revealed 7 residents were seated in wheelchairs or reclining chairs, in a line along the wall, with an over bed table placed in front of them, waiting for their lunch trays. Continued observation, in the 3rd floor dining room revealed no tables. Observation on 6/9/15, at 5:30 PM, in the 4th floor dining room revealed a total of 8 residents in the dining area. Three residents were seated at a single table in their wheelchairs and 5 residents were seated in wheelchairs with an over bed table placed in front of them with their meal tray on the table.	F 252	2. Unless it causes distress or behaviors for residents who cannot voice preferences, a trial, to begin the week of 07/06/15, will be conducted regarding those residents eating their meals in the Family Room on the first floor where there are tables available. The Director of Nurses (DON) spoke with three families who all preferred that their loved ones eat in the Family Room if this is found to be appropriate. 3. Unless it causes distress or behaviors, residents who require extensive or max assistance in dining will participate in a trial, to begin the week of 07/06/15, regarding those residents eating their meals in the Family Room on the first floor where there are tables available. By 07/03/15, nursing stations will be removed on the 3rd and 4th floors to allow for additional space and a more homelike environment to include tables for both dining and activities. 4. The DON, administrator or designee, will observe these dining experiences weekly times four weeks, then monthly times three months. If experiences are unsuccessful, a Root Cause Analysis with Plan, Do, Study, Act Cycle will be initiated and taken to the Quality Assurance Committee.	

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F 252	Continued From page 3 Observation on 6/9/15, at 5:46 PM, in the 3rd floor dining room revealed 8 residents seated in wheelchairs with an over bed table placed in front of them awaiting evening meal tray. Interview with Certified Nursing Technician (CNT) #1, on 6/8/15, at 11:40 AM, in the third floor dining room revealed, "They use to have tables in this area, but they took them out about 3 or 4 months ago...I don't know why." Interview with Certified Nurse Technician (CNT) #2, on 6/9/15, at 5:30 PM, revealed "some of the [over bed] tables come out of their rooms, but we keep some in there [dining room] for those that normally eat in there." Interview with the Administrator on 6/10/15, at 7:42 AM, in the Director of Nursing's office, confirmed over bed tables were being utilized in the 3rd and 4th floor dining rooms in place of tables.	F 252		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		

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F 278	Continued From page 4 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to accurately assess the functional status of 1 resident (#12) of 25 residents reviewed. The findings included: Medical record review revealed Resident #12 was admitted to the facility on 9/4/14, with diagnoses including Chronic Pain, Constipation, General Osteoarthritis, Dysphagia, History of Transient Ischemic Attacks, and Insomnia. Medical record review of the quarterly Minimum Data Set (MDS) dated 2/12/15, revealed no impairment of the upper or lower extremities. Medical record review of the quarterly MDS dated 5/10/15 revealed the resident had impairment of the upper and lower extremities.	F 278	1. On 06/22/15, Resident #12 was reassessed on a quarterly Minimum Data Set (MDS) to correct the data entry error. 2. On 06/22/15, Nursing Administration completed a 100% audit of all assessments within the last 90 days for data entry errors to section G0400. Two other assessments were found to be miscoded and on 06/25/15 new assessments were completed. 3. Beginning 06/24/15, the Life Enrichment Technician, or designee, will evaluate range of motion for all residents in their Assessment Reference Date window. Evaluations will be reviewed by the MDS Coordinator prior to completion of the MDS. 4. The Director of Nurses (DON), or designee, will review each G0400 section prior to closing the MDS for 90 days. If no errors are noted, the reviews will be discontinued. If errors are noted, the DON, or designee, will conduct a Root Cause Analysis with Plan, Do, Study, Act Cycle with continued audits until compliant. Results will be taken to the Quality Assurance Committee.	07/30/15

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F 278	Continued From page 5 Observation of the resident on 6/10/15, at 8:09 AM, with Licensed Practical Nurse (LPN) #5 in the resident room, revealed the resident did not have any contractures of the upper or lower extremities. LPN #5 stated the resident's condition had not changed regarding extremity functions. Interview with the Director of Nursing (DON) on 6/10/15, at 8:50 AM, in the conference room, confirmed "The MDS Coordinator had entered inaccurate information on the MDS for May 2015. The MDS is incorrect. The resident did not have any functional decrease in her extremities."	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, the facility had failed to provide assistance to maintain continence care for 1 resident (#61) of 25 residents reviewed. The findings included: Review of the facility's policy, Bedpan/Urinal, Offering/Removing, revised October 2010, revealed " ... Do not allow the resident to sit on a bedpan for extended periods ..."	F 312	1. A skin assessment for resident #61 was completed for three days (06/11/15-6/13/15) with no skin concerns noted. On 06/24/15, an audit of all residents needing assistance for activities of daily living was completed by nursing staff and five residents requiring a bed pan were identified. 2. On 06/24/15, interviews were conducted with residents and staff to obtain bedpan time preferences for all residents who use a bedpan. 3. The following fixed care plan was developed on 06/24/15 to be added to all residents who use a bedpan and will go to the Certified Nursing Technicians' kiosks: "My preferred bedpan use times are ____. Please remove me promptly from the bed pan. Please alert the charge nurse if I require an extended amount of time on the bedpan." Care plans were implemented on 06/25/15. 4. The Director of Nurses, or designee, will review with each care plan review and problems will be taken to the Quality Assurance Committee.	07/30/15

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F 312	Continued From page 6 Medical record review revealed Resident #61 was admitted to the facility on 11/20/13, with diagnoses including status post open reduction, internal fixation (ORIF) right hip, joint pain, general osteoarthroses, hypertension, and depressive disorder. Medical record review on 6/8/15, of the Quarterly Minimum Data Set dated 5/15/15, revealed the resident was totally dependent on staff for bed mobility, transfer and toileting needs. Review of the resident's care plan with a goal date of 8/28/15, revealed " ...I am incontinent of bowel and bladder. I use a bedpan. total assist with toileting and Peri care ..." Interview with the Resident on 6/8/15, at 2:56 PM, in the resident's room, confirmed on 6/7/15, the resident had pushed the call light at 8:50 PM and was placed on the bedpan. Continued interview confirmed at 9:50 PM, she pushed her call light to get help to be removed from the bedpan. Continued interview confirmed at 11:15 PM, the resident had not been removed from the bedpan, and removed the bedpan herself. The resident stated she did not see any facility staff until "a tech[certified nurse technician] came in at ten minutes 'til four." Interview with the Director of Nursing (DON) on 6/10/15, at 3:37 PM, in the DON's office, confirmed "fifteen to twenty minutes was a reasonable length of time for being on the bedpan" and the facility had failed to provide assistance to maintain continence care for Resident #61, and had not followed their policy.	F 312		

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F 371	Continued From page 7			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and interview, the facility failed to maintain a sanitary kitchen by not properly maintaining one of one walk-in freezer, and by failure to sanitize the hands during food service. The findings included: Review of the facility policy Purchasing, Receiving, and Storage, no date, revealed "...Food will be properly stored to preserve...safety...All food will be stored in areas protected from contamination by condensation, leakage, drainage..." Review of the facility policy Handwashing Policy, no date, revealed "Purpose: To prevent the spread of communicable disease...After touching hands to the face..." Observation with the Cook on 6/8/15, at 10:23 AM, in the kitchen, of the walk-in freezer, revealed ice build-up on the floor, evidence of	F 371 F 371	#1 1. On 06/08/15, dietary staff cleaned the ice build-up and debris from the floor of the walk-in freezer, covered the black foam insulation and destroyed the affected food. 2. The walk-in freezer was placed on a routine cleaning schedule. 3. The freezer will be checked daily for any ice accumulation which will be removed if build-up occurs. Dietary staff will be in-serviced quarterly on proper cleaning of the walk-in freezer by the Registered Dietician (RD) and/or Certified Dietary Manager (CDM.) The pipes in question were wrapped in metal by the Director of Environmental Services on 06/18/15. 4. The CDM or shift leader will check the walk-in freezer daily for 30 days. The RD will perform an audit monthly for three months and discontinue if compliant. If non-compliant, a Root Cause Analysis with Plan, Do, Study, Act Cycle will be completed and taken to the Quality Assurance Committee.	07/30/15

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F 371	Continued From page 8 debris in the left corner and around the edges of the floor and under the racks, a 4 ounce (oz) strawberry ice cream, a 4 oz orange sherbert, a 4 oz lime juice, and 1 pancake on the floor of the cooler. Continued observation of the walk in freezer revealed a pipe wrapped in black insulation, with 2 boxes of unsealed yeast sweet rolls with black debris from the insulation in the boxes, and 1 box with 8 loaves of garlic bread. Continued observation revealed the 3 boxes had ice build-up and were available for resident use. Interview with the Cook, on 6/8/15, at 10:26 AM, in the kitchen, confirmed the facility failed to maintain cleanliness and failed to properly store food items, in the walk-in freezer. Observation with the Cook on 6/8/15, at 11:15 AM, in the kitchen, revealed the Cook with gloved hands took her apron, wiped her face, opened the food warmer, removed 1 bowl of pureed food, returned to the tray line without washing the hands, and continued to serve food. Continued observation at 11:23 AM, revealed the Cook with gloved hands took her apron wiped the face, opened the food warmer, removed 2 bowls of pureed food, changed the gloves, without washing the hands, and continued to serve the food. Interview with the Cook, on 6/8/15, at 11:25 AM, in the kitchen, confirmed the facility failed to maintain a sanitary kitchen and had failed to follow the facility's handwashing policy.	F 371	1. On 06/09/15, the Certified Dietary Manager (CDM) conducted a one on one in-service with the cook in question regarding proper hand washing. 2. On 06/10/15, the CDM conducted an in-service for dietary staff members regarding proper hand washing. 3. On 06/30/15, the Registered Dietician (RD) conducted audits/ in-service training for dietary staff with return demonstration if needed. Audits will continue monthly times three months and then quarterly. 4. The CDM or RD will observe the cooks' hand washing techniques weekly for four weeks then monthly for three months and discontinue if compliant. If non-compliant, a Root Cause Analysis with Plan, Do, Study, Act Cycle will be completed and taken to the Quality Assurance Committee.	07/30/15
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 9 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation	F 441	#1 1. Observations for hand washing during meal service were started on 06/11/15 by the administrative nursing staff. 2. One on one instruction and/or return demonstration was provided as needed during the observations. 3. Hand sanitizer was added to the outside of the food cart liners on 06/24/15. A hand sanitizer station was added to the 4th floor dining area and reminder signage ("Please remember to cleanse hands between each resident encounter.") was posted on 06/24/15. 4. The Director of Nurses, Quality Assurance Nurse or designee will observe meal time hand washing weekly for four weeks, then monthly for three months and discontinue if compliant. If non-compliant, a Root Cause Analysis with Plan, Do, Study, Act Cycle will be completed and taken to the Quality Assurance Committee. #2 1. Observations for hand washing during medication administration were started on 06/11/15 by the administrative nursing staff. 2. One on one instruction and/or return demonstration was provided as needed during the observations. 3. Hand foam was added to the 4th floor medication cart near the sharps container on 06/12/15 with hand foam completed on all carts on 06/23/15. 4. The Director of Nurses, Quality Assurance Nurse, or designee, will observe medication pass hand washing weekly for four weeks, then monthly for three months and discontinue if compliant. If non-compliant, a Root Cause Analysis with Plan, Do, Study, Act Cycle will be completed and taken to the Quality Assurance Committee.	07/30/15 -07/30/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44A114	A. BUILDING _____ B. WING _____	06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10 and interview, the facility failed to follow infection control practices to minimize the potential for cross contamination between residents at meal times for 5 of 12 residents observed, failed to follow infection control guidelines for handwashing during medication administration for 1 resident of 4 residents observed, and failed to ensure resident care lifts were cleaned between residents, on 2 of 2 resident units observed. The findings included: Review of the facility policy, Handwashing/Hand Hygiene, revised 4/2010, "...If hands are not visibly soiled, use an alcohol-based hand rub...before and after direct contact with residents..." Observation on 6/8/15, at 12:03 PM, on the fourth floor dining room revealed Certified Nursing Technician (CNT) #3 feeding a male resident. Continued observation revealed CNT #3 stood up and without disinfecting the hands, walked to a female resident, seated at a different table, patted her back, then held to the back of the chair, and proceeded to assist her with eating. Continued observation revealed CNT #3 walked away from the female resident and resumed feeding the male resident without disinfecting the hands. Continued observation at 12:07 PM through 12:09 PM, revealed CNT #3 continued to assist both residents without disinfecting the hands. Observation on 6/9/15, at 5:50 PM, in the 4th floor dining room, revealed CNT #3 was feeding a resident, began feeding another resident, and then wiped a third resident's mouth. Continued observation revealed CNT #3 returned to the first resident to assist with feeding without washing or	F 441	#3 1. On 06/10/15, all lift equipment was deep cleaned by the nursing staff. 2. All lift equipment was cleaned. 3. On 06/24/15, red cleaning instruction labels were applied to all lift equipment. 4. Beginning the week of 06/15/15, the Life Enrichment Technician, or designee, will check lifts each week for cleanliness with report to the Director of Nurses. These checks will continue weekly for four weeks. If compliant will continue monthly for three months and then discontinue if compliance remains. If non-compliant, a Root Cause Analysis with Plan, Do, Study, Act Cycle will be completed and taken to the Quality Assurance Committee.	07/30/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 11 sanitizing the hands. Interview with CNT #3 on 6/9/15, at 5:53 PM, in the dining room, confirmed CNT #3 failed to wash or sanitize the hands after touching the third resident's mouth. Review of the facility's policy, Infection Control Guidelines for All Nursing Procedures, revised September 2012, revealed, "...Employees must wash their hands...after handling items potentially contaminated with blood..." Observation on 6/9/15, at 7:41 AM, revealed Licensed Practical Nurse (LPN) #2 administering medications in the hallway. Continued observation revealed the LPN disposed of a pill in the dirty sharps container, continued preparing medications, and failed to wash the hands. Interview with LPN #2 on 6/9/15, at 7:41 AM, in the hallway, confirmed the hands were not washed after touching the dirty sharps container. Review of the facility policy, Cleaning and Disinfection of Resident-Care Items and Equipment, revised October 2009, revealed "...resident-care equipment, including reusable items and durable medical equipment will be disinfected...between resident..." Observation on 6/10/15, at 1:32 PM, on the 3rd and 4th floors revealed 4 resident care lifts on each floor with heavy grey debris at the front of the lift. Further observation revealed on the top side of the lifts bases had discolored stains. Interview with the Housekeeping/Laundry Supervisor on 6/10/15 at 2:30 PM, in the lobby,	F 441		

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F 441	Continued From page 12 confirmed the resident care lifts on the 2 resident units were dirty, and confirmed the facility failed to ensure the resident care lifts were cleaned between residents.	F 441	1. On 06/25/15, the activity director conducted an audit of preferences for residents who eat in the dining areas on the 3rd and 4th floors regarding eating at a dining table or eating on over bed tables for meals. Six of the interviewable residents expressed the preference of eating at a table and two expressed the preference to eat on over bed tables or at a table. Those residents who choose to eat on over bed tables for meals will be care planned accordingly. 2. Unless it causes distress or behaviors for residents who cannot voice preferences, a trial, to begin the week of 07/06/15, will be conducted regarding those residents eating their meals in the Family Room on the first floor where there are tables available. The Director of Nurses (DON) spoke with three families who all preferred that their loved ones eat in the Family Room if this is found to be appropriate. 3. Unless it causes distress or behaviors, residents who require extensive or max assistance in dining will participate in a trial, to begin the week of 07/06/15, regarding those residents eating their meals in the Family Room on the first floor where there are tables available. By 07/03/15, nursing stations will be removed on the 3rd and 4th floors to allow for additional space and a more homelike environment to include tables for both dining and activities. 4. The DON, administrator or designee, will observe these dining experiences weekly times four weeks, then monthly times three months. If experiences are unsuccessful, a Root Cause Analysis with Plan, Do, Study, Act cycle will be completed and taken to the Quality Assurance Committee.	07/30/15
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide dining tables for dining in 2 of the 3 dining rooms observed. The findings included: Observation on 6/8/15, at 11:30 AM, in the 3rd floor dining room, revealed 7 residents were seated in wheelchairs or reclining chairs in a line, along the wall, with an over bed table placed in front of them waiting for their meal tray to be served. Continued observation revealed there were no dining tables in the dining room. Observation on 6/9/15, at 5:30 PM, in the 4th floor dining room, revealed a total of 8 residents in the dining room. Continued observation revealed 1 dining table and 3 residents seated in wheelchairs around the table. Continued observation revealed 5 other residents were	F 464		

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F 464	Continued From page 13 seated in wheelchairs with an over bed table placed in front of them with their meal placed on the over bed table. Observation on 6/9/15, at 5:46 PM, in the 3rd floor dining room, revealed 8 residents seated in wheelchairs with an over bed table placed in front of them waiting for their meal to be served. Interview with Certified Nurse Technician (CNT) #2, on 6/9/15, at 5:30 PM, revealed "some of the [over bed] tables come out of their rooms, but we keep some in there [dining room] for those that normally eat in there." Interview with the Administrator, on 6/10/15, at 7:42 AM, in the Director of Nursing (DON) office, confirmed over bed tables were being utilized in the 3rd and 4th floor dining rooms in place of dining tables.	F 464		